SUPERVISOR'S ACCIDENT PACKET INSTRUCTIONS

These instructions are for the supervisor who is receiving an employee's report of incident.

STEP 1: To complete the City of Houston Accident Report you will need to request the employee to provide you with all information pertaining to their report of incident. The employee's responses will be documented as follows:

- Supervisor completes Sections 1 – 4
- **Employee must Circle Injured Area(s)**
- Supervisor completes Sections 5 – 8
- Supervisor completes Sections AA – CC
- Employee completes Sections DD – EE

STEP 2: Review and explain each section of the COH On-The-Job-Injury Reference Sheet to the employee.

- The employee is to initial each section and sign the bottom of the sheet.
- You will complete and sign the bottom of the sheet.
- Give the employee the copy of the COH On-The-Job-Injury Reference Sheet that does not contain the employee number and date of injury.

STEP 3: The employee will complete and review the HIPAA Authorization for Disclosure of Protected Health Information.

- The employee will print their name in the space provided at the top of the document.
- The employee will review the document.
- The employee will sign and date the document.
- The employee will print their name, address, telephone and social security number at the bottom of the document.
- In the event an employee refuses to sign this document, the supervisor must note this on the document.
- **Keep this document for your records.**

STEP 4: Give the employee the Summary Workability Guidelines E.O. 1-33 (For Injured Employees) Booklet, MSC Worker's Compensation Rx Program and the Lost Time Claim Flow Chart.

STEP 5: Upon completion of the Supervisor's Accident Packet, contact our third party administrator's claim reporting service.

- Call (866) 678-1748
- Use the completed City of Houston Accident Report to answer all questions asked by the intake operator.
  - ★ **NOTE**: the intake operator's questions will follow the order of the City of Houston Accident Report.
- Document the reference # provided by the intake operator in Section FF of the City of Houston Accident Report.

STEP 6: Forward a copy of the supervisor packet to your assigned DDR.

★ **TRAINING FOR THE SUPERVISOR'S ACCIDENT PACKET IS AVAILABLE ONLINE AT www.houstontx.gov/hr/wcpages/wc.htm**

Supervisor's Accident Packet

Accident Report

On The Job Injury Reference Sheet

*** Supervisor reports the claim to Claims Reporting Service (CRS) at (866) 678-1748 within 24 hours! ***

HIPAA Medical Release Form

Summary Workability Guidelines E.O. 1-33 (For Injured Employees) Booklet

MSC Prescription Program

Lost Time Claim Flow Chart

City of Houston Accident Report

1. Incident Type						
	Safety	☐ Property Damage	☐ Near Miss	☐ Incident Only	☐ First Aid	☐ Illness
	Workers' Compensation	☐ Medical		☐ Lost Time		☐ Fatality

2. General Information

A. Name Of Injured Employee	B. Employee #	C. Social Security Number

D. Primary And Secondary Telephone Numbers For Employee Contact		E. Occupation of Injured Employee	F. Date of Injury	Time Of Injury
1.	2.			☐ AM ☐ PM

G. Date Reported	Time Reported	H. Supervisor To Whom Incident Was Reported	I. Supervisor Contact Number
	☐ AM ☐ PM		

J. Primary Language Spoken By Employee	K. Race Of The Injured Employee (ie: White, Black, Asian)	L. Ethnicity Of The Injured Employee (ie: Hispanic, Native American, Other)	M. Rate Of Pay At This Job
			_____Hourly _____Weekly

N. Full Work Week Is	O. Last Paycheck Was	P. Length Of Service In Current Position	Q. Length Of Service In Occupation
_____Hours _____Days	_____For _____Hours/Days	_____ Years _____Months	_____ Years _____Months

3. Medical Information

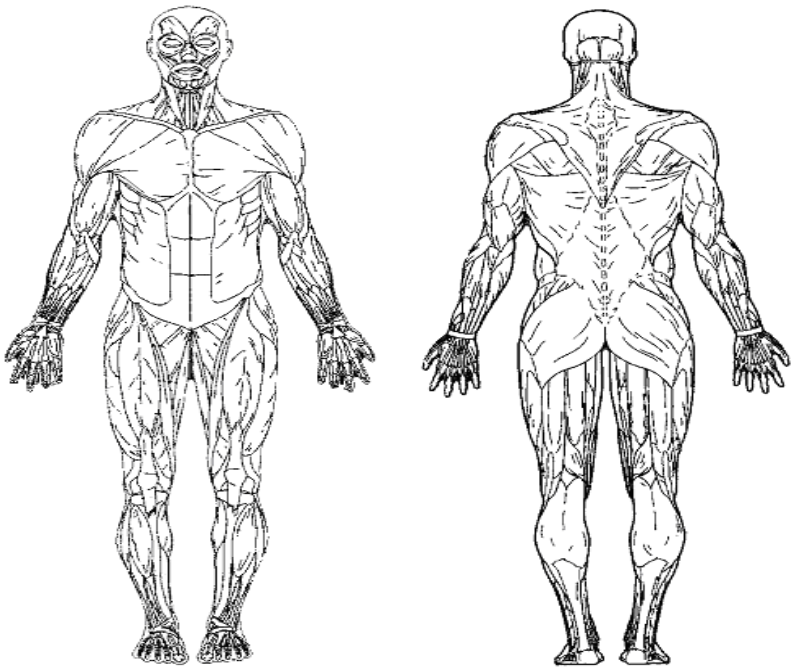
R. Medical Treatment Requested	S. Name, Address And Telephone Number Of Treating Facility
☐ Yes ☐ No	

4. Witness Information

T. Witness	U. Witness Contact Number(s)

For Employee Use Only:

Circle Injured Area(s)



City of Houston Accident Report

5. Employee Description Of How And Why Injury/Illness Occurred:
Employee States: **Supervisor States:**

6. Nature Of Injury: (Example: Laceration, Burn, Fracture)

7. Cause Of Injury: (Example: Fall, Trip, Struck, Caught)

8. Additional Accident Information	
V. Address Where Injury/Exposure Occurred	W. Location At Time Of Incident
X. Activity At Time Of Incident	Y. Equipment Involved
Z. Other Items/Tools Involved	

AA. Name Of Person Completing Form	**BB. Title Of Person Completing Form**	**CC. Date Form Completed**
DD. Employee Signature	**EE. Date Form Signed**	**FF. Reference #**

COH ON THE JOB INJURY REFERENCE SHEET

(Must be signed by the employee for confirmation of receipt)
For detailed employee benefits and responsibilities see your Summary Workability Guidelines E.O. 1-33 (For Injured Employees) booklet

_____ If required your supervisor will take or direct you to nearest medical facility.

_____ You have your choice of treating doctor. The minor emergency clinic or hospital attended at the direction of your supervisor is not considered your choice of treating doctor. He/she must be on the Approved City and TDI Doctors List, which can be further accessed as described in the booklet, or obtain information from your supervisor. Contact your assigned adjuster as soon as you are aware of your treating doctors information or within 48 hours of accident. The adjuster will need this information to authorize medical treatment.

_____ In this packet you have been given a sheet that contains pharmacies where you can obtain medications, which have been found to be reasonable and related to your on-the-job-injury, at no cost to you. The name of the subcontractor taking care of this WC benefit can be found in your booklet.

_____ You must cooperate with investigation. Complete the accident form with your supervisor, answer supervisor and safety officer questions and expect a call from the Third Party WC Administrator within 48 hours of your injury to take a detail recorded statement.

_____ Any change in work status must immediately be communicated to your supervisor, Administrative coordinator and adjuster to ensure that the proper benefits are initiated or stopped. This will prevent an overpayment causing hardship at time of mandatory reimbursement to the City.

_____ You must contact your adjuster after every doctor's or treating doctors referral visit (this does not include PT visits), if unable to reach your adjuster insure that your message includes; current work status, treatment plan given by the doctor, next office visit date.

_____ Contact your Pension Representative to determine how WC benefits affect your pension and retirement.

_____ Your department will be keeping daily contact as you are required to be available with the exception of medical care, COH business appointments, and meetings with the TDIWC or TPA.

_____ You may be required to attend safety classes while on injury leave.

_____ You have received a booklet as part of your injury packet containing contact numbers, salary continuation policy and quick reference part of the requirements under Executive Order 1-33. The complete executive order can be found at the city website.

_____ It will be deemed that past payments made by City of Houston payroll pending resolution of compensability will be considered as payments of TIBs per Labor Code 408.105. Salary Continuation and accruals will be replenished by the amount of past TIBs owed based on the outcome of dispute resolution.

_____ **I agree that any overpayments paid in any form as well as any other City funds paid to me that should not have been paid to me may be deducted from my future earnings so long as such deductions do not reduce my earnings below minimum wage in any pay period in which such deductions are made. [NOTE: Failure to initial this section renders injured employee ineligible for salary continuation benefits.]**

_____ Initialing here confirms that you have received a copy of this document.

_____

By initialing each section and signing the bottom of this page you agree that your supervisor fully explained each point and that you have received your injury packet, which includes the booklet. Your supervisor will keep your acknowledgement, which will be kept in your personnel file for documentation.

Employee Number: _____ Date of Injury: _____

Employee Signature: _____ Today's Date: _____

Supervisor Signature: _____ Today's Date: _____

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Authorization for Disclosure of Protected Health Information

I, _____ [Your Name], authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

All healthcare providers who have provided healthcare services to me. All insurance carriers and/or Third Party administrators with whom I have filed claims.

2. I authorize the following person(s) and/or organization(s) to receive my protected health information as disclosed by the person(s) and/or organization(s) below.

City of Houston on behalf of: Third Party Administrator,

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.

I further specifically authorize the disclosure of psychotherapy notes, if any.

4. This information may be used by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) names above have taken action in reliance on this authorization.

6. This authorization expires on one year from the date of this authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____
Signature Date

Name: _____

Address: _____

Telephone: _____ SSN: _____

_____
Relationship or Authority of Personal
Representative (if applicable)

WORKER'S COMPENSATION Rx PROGRAM

The top portion of this form must be completed before giving it to your pharmacist.

Injured Employee: _____ Social Security #: _____ Date of Injury: _____

Employee Phone: _____ Employee Date of Birth: _____ Description of Injury: _____

Employer Name: City of Houston Division: _____ Employer Representative: _____ Phone: _____

To Employee:
On your first visit, please give this notice to any pharmacy listed on this panel to expedite the processing of your approved workers' compensation prescriptions. Based on the established parameters by your employer.

To Pharmacist:
This employer has selected MSC – Medical Services Company to administer its workers' compensation prescription drug program through the RESTAT network. For immediate authorization and on-line billing information contact MSC at: 1-800-848-1989 ext 1414, state that you have received a letter of intent and give the MSC patient care coordinator the control number located in the bottom right hand corner of this form.

CHAINS PARTICIPATING IN THE PHARMACY NETWORK

A & P PHARMACY
ALBERTSONS
ARBOR DRUGS
ARROW PRESC. CTR.
AURORA
BARTELL DRUG
BI-LO PHARMACY
BI-MART DRUG
BIG BEAR
BROOKS PHARMACY
BROOKSHIRE
BRUNO'S
CARRS
CITY MARKET
COSTCO
CUB PHARMACY
CVS PHARMACY
D & W PHARMACY
DILLON PHARMACY
DISCOUNT DRUG MART
DOMINICK'S
DRUG EMPORIUM
DRUG FAIR
DUANE READE
EDGEHILL PHARMACY
EDWARDS PHARMACY
FAGAN PHARMACY
FARMER JACK PHARMACY
FAY'S DRUG STORE
FINAST PHARMACY
FOOD TOWN PHARMACY
FRED MEYER
FRY'S FOOD & DRUG
FURR'S PHARMACY
GENOVESE DRUG STORE
GIANT EAGLE PHARMACY
GIANT FOOD INC.
GIANT PHARMACY
GRAND UNION PHARMACY
HANNAFORD DRUG
HARCO DRUG
HARVEST FOODS PHARMACY
H-E-B PHARMACY
HI-SCHOOL PHARMACY
HORIZON
HY-VEE PHARMACY
INTEGRATED PHARMACY
K & B PHARMACY
K-MART
KARE DRUGS
KASH & KARRY PHARMACY
KERR DRUG STORE
KING SOOPERS
KINNEY DRUGS
KROGER DRUG
LONG'S DRUG STORE
MANAGED PHARMACY CARE
MARC'S PHARMACY
MAXI/BROOKS PHARMACY
MEDICAP PHARMACY
MEDIC DISC. DRUG
MEDICINE SHOPPE
MEDISTAT PHARMACY
MEIJER PHARMACY
OSCO DRUG
PAMIDA PHARMACY
PERRY DRUG STORE
PRICE CHOPPER
PRICE COSTCO PHARMACY
PUBLIX PHARMACY
RANDALL'S FOOD MARKETS
RITE-AID PHARMACY
RITZMAN PHARMACY
SACK N' SAVE
SAFEWAY PHARMACY
SAV-ON DRUGS
SAVE-MART PHARMACY
SCHNUCK'S PHARMACY
SHOP N' SAVE DRUGS
SHOPKO PHARMACY
SMITH'S FOOD & DRUG
SNYDER
STOP & SHOP PHARMACY
SUPER D DRUGS
TARGET PHARMACY
TEXAS DRUG WAREHOUSE
TEXAS ONOCOLOGY
THRIFT DRUG
THRIFTY/PAYLESS DRUG
THRIFTY WHITE DRUG
TIMES PHARMACY
TOM THUMB/PAGE DRUG
TOPS PHARMACY
UNITED MANAGED CARE
UNITED PHARMACY
VON'S PHARMACY
WAL-MART PHARMACY
WALGREENS
WEIS PHARMACY
WELBY SUPER DRUG

Control Number: 01260

Lost Time Claim Flow Chart